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ABSTRACT

While formal definitions of "psychotherapy" have been notoriously elusive, there appears to be general agreement that it involves a professional relationship between a person seeking help for an emotional or behavior problem and a professional who is recognized by society as possessing a certain expertise. An important concomitant of this conception is the existence of an implicit or explicit contract between the participants, together with responsibilities that each party must fulfill. Various advertised "self-help" programs are often misleading or even dangerous in the promises they hold out or the problems they offer to solve. Many factors, such as a client's built-in reluctance to change, can hardly be handled effectively in an entirely self-administered program. Psychology as a profession has a clear responsibility to educate the public on the subject of realism and feasibility in the area of personality and behavior change. (Author/BP)

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Nonprescription Psychotherapies: Can We Dispense with the Therapist?*

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Until Dr. Gerald Rosen invited me to participate in this symposium

I had not given much thought to the problems posed by so-called nonprescription psychotherapies. Since then I have gained some familiarity with the literature and profited from the excellent review by Glasgow & Rosen (in press) as well as other writings. While I have no special expertise in the area, I have concerned myself a great deal about psychotherapy and the research, professional, and ethical problems surrounding its practice. Furthermore, my research group has in recent years done considerable work on the problem of negative effects in psychotherapy (Strupp, Hadley, & Gomes-Schwartz, in press). Some extrapolations from these efforts may therefore be helpful.

Let me first address some basic definitional problems. When a treatment modality of whatever description is presented to the public and its proponents proclaim that it ameliorates problems in living or psychopathology however defined, it is incumbent upon those who advance such claims to specify (a) the nature of the problem or problems it is supposed to help; (b) the conditions under which it is helpful (or harmful); (c) the kinds of changes or improvements that may reasonably be expected; (d) the operations necessary to bring about the change; and (e)--perhaps somewhat further down the road--the advancement of reasonable theoretical formulations to explain the treatment's modus operandi. Each of these requirements entails careful definition

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of variables, the description of measurement or assessment operations, and the ruling out of alternatives, e.g., the possibility that the observed changes are "spontaneous," that is, due to extraneous factors unrelated to the treatment under investigation (Strupp, Hadley, Gomes-Schwartz, ch. 2).

As long as psychotherapy was regarded as a form of medical treatment and the problems brought to the psychotherapist were seen as analogous to "diseases," one could speak about "cure," "spontaneous remission," or "deterioration." Residues of this conception are of course still very much alive, for example, when claims for reimbursement under various insurance schemes are handled on this basis. However, when neurotic problems gradually came to be viewed as "problems in living," rather than "health problems," a new approach became necessary. A further change in conceptions was ushered in when a host of "new" therapies came upon the scene, some of which grew out of the human potential movement while others were spawned by the approaches loosely grouped under the heading of behavior therapy. The nonprescription therapies aimed at phobias, smoking, obesity, sexual dysfunctions, lack of assertiveness, etc. exemplify the extraordinarily wide range of problems which psychologists, along with other mental health professionals, have begun to tackle.

If treatment merges with training, if neurotic problems become indistinguishable from existential anxieties, faulty habits, defective self-regulation, etc., what remains of the meaning of such terms as "patient," "therapist," and "therapy?" It is readily apparent that the boundaries between treatment, growth, instruction, and training have become increasingly obscured. Indeed, these terms may be on the verge of losing most of their meaning. What is left is (1) a set of feelings, cognitions, or behaviors

which someone defines as a "problem," (2) a set of operations which are purported to bring about beneficial changes in this problem, and (3) an outcome or end result which someone defines as an "improvement" or a "cure."

As Strupp, Hadley, & Gomes-Schwartz (1977) have developed elsewhere, terms like "mental health" or "improvement" in psychotherapy depend heavily on the values someone assigns to feelings, cognitions, and behavior. We distinguished values espoused by (1) the consumer, client, or patient, (2) the society in which we live, and (3) mental health professionals who, in keeping with their theoretical orientation and other variables, define a person's psychological functioning as sick or healthy, adaptive or maladaptive, etc.

By this reasoning, conditions like smoking, obesity, nonassertiveness, premature ejaculation, etc. are not "problems" until someone--the individual, society, or an expert--defines them as problems. Similarly, changes in these conditions are not "improvements" until someone defines them as such. These problems equally plague assessments of the "effectiveness" of traditional psychotherapy, behavior therapy, and the administered therapies. They are not problems of research design, measurement, or science--they are problems of definition and value. Furthermore, until we can achieve clarification of the terms, we cannot meaningfully address ourselves to problems of professional ethics.

For a variety of reasons it seems most unfortunate to use the term "psychotherapy" for the spectrum of self-administered programs which purport to bring about "therapeutic change." While formal definitions of "psychotherapy" have been notoriously elusive, there appears to be general agreement that it involves a professional relationship between a person seeking help

for an emotional or behavior problem and a professional who is recognized by society as possessing a certain expertise. An important concomitant of this conception is the existence of an implicit or explicit contract between the participants, together with responsibilities that each party must fulfill. Prominent among the therapist's responsibilities are sustained effort to engage in operations that are regarded as helpful, avoidance of operations that may foreseeably be harmful, and the diligent application of professional expertise in the service of the client. Thus, malpractice refers to violations of one or the other of these professional canons. Furthermore, what the client purchases from the professional is not only "effective" services but a presumably greater expertise than the client possesses himself. I make this point to underscore the fact that even if a self-help program can be shown to be more effective than a therapist-administered regimen, it does not necessarily follow that the consumer is "better off" with the former or that henceforth we can dispense with professional therapists. It is apparent that a "treatment" may be highly "effective" (by some standard) but it may have highly harmful or injurious "side effects." A self-administered starvation diet to produce rapid weight loss may suffice as an example. I conclude that the term "psychotherapy" should be restricted to those interventions in which a professional takes responsibility for the treatment as well as the welfare of his client. As a profession we should strenuously resist efforts to broaden the term to do-it-yourself programs. I believe such a move in itself would go some distance in dissociating ourselves from the plethora of programs, books, and manuals that are flooding the market.

I further agree with the points made by Rosen (1976) that responsible professionals who develop and offer to the public self-help programs of any

kind owe it to their profession as well as the public to spell out in clear language the expectable gains, hazards, and limitations of their "product." An appropriate APA standards committee may well be the best vehicle for monitoring these activities. Rosen's message that "governments inevitably move into a regulatory position when professionals fail to responsibly protect consumers" (1976, p. 140) should ring loud and clear; it applies not only to nonprescription therapies but has equal cogency for many other forms of "psychotherapy" offered to the public today.

The consumer clearly has the right to be protected from exaggerated or misleading claims--whether they are made by pharmaceutical firms, cereal manufacturers, or mental health professionals. Consumers should be placed in a position from which they can make an informed choice of what is good or in their interest. The problem, unfortunately, is more complicated. An argument frequently advanced in favor of prescription drugs is that the consumer lacks the necessary expertise to make an appropriate judgment and that a physician is far better qualified to do so. While I have sympathy for the position advanced by authors like Szasz (1974), that intelligent adults should take responsibility for their decisions affecting their lives instead of letting "Big Brother" do it for them, it is a simple fact that consumers very often cannot make the appropriate judgment and self-diagnosis may be treacherous.

To illustrate: For a good many years people have enrolled in encounter groups or similar experiences for the ostensible purpose of enhancing their "human potential" or for "personality growth." While many participants have derived benefits (usually defined by themselves), there is also evidence to show (Hartley et al., 1976) that a certain percentage of the participants suffer adverse effects. Equally important, a substantial number of persons,

while ostensibly seeking "growth," actually come to solve more or less severe personal problems which have little chance of being ameliorated in such a context. In short, human beings, as we know, have a remarkable capacity for deceiving themselves, for hiding problems from themselves and others, and for asserting that the problem is of a certain kind when it really is something very different.

In many cases, smoking, obesity, deficient study skills, nonassertiveness, etc. may be the "problem" for which an individual seeks a solution via self-administered programs. In other instances, the problem or the changes the person is seeking may be of a different order. All therapists have seen clients who come for help after having unsuccessfully tried a number of techniques that have left them more discouraged and disillusioned than they were before (Hadley & Strupp, 1976). It follows not only that a professional is better equipped to "diagnose" a problem but that there may be cogent reasons, interwoven with the nature of the problem, why the client prefers self-diagnosis and self-help to the risk of trusting a professional, or simply another human being. In short, the client's vaunted autonomy or independence may be a pseudo autonomy or independence, disguising pervasive dependency wishes and needs.

When one is dealing with relatively discrete behaviors (e.g., smoking), self-administered programs may be notably effective, but as Glasgow & Rosen's (in press) review demonstrates, there are many "drop-outs" from self-administered treatments. Conversely, there exists greater likelihood of success when a therapist is involved in one capacity or another. This finding raises a host of provocative questions, including one that particularly interests me. I am referring to the role and function of the therapist. Indeed, one might say that psychotherapy begins when self-help fails.

Let me elaborate. A question the professional therapist frequently has to confront relates to the discrepancy between a client's desire to feel, think, or act in a desired way and his manifest inability to do so. People may want to use airplanes but they become anxious when they take a flight; a person recognizes that smoking is harmful, but he is unable to stop; a person wishes to be assertive but cannot overcome his timidity, etc. Such people are usually in conflict or they proclaim that for mysterious reasons they cannot help themselves. They want change but somehow they oppose change or they sabotage their own or a therapist's efforts to bring it about. Concepts like "conflict," "motivation," and "resistance" are common in psychotherapy and they have proved their utility.

To bring about therapeutic change, the person clearly must be motivated and the motivation for change must be stronger than the forces opposing change. The therapist therefore must seek to bolster the patient's desire for change and undercut the forces impeding change. This feat may be accomplished in a variety of ways--for example, by confronting the client with contradictions or inconsistencies in his beliefs, assumptions, etc., supporting his strivings for independence and mastery, discouraging maladaptive behaviors, and many others. How do these maneuvers compare with what happens in a self-help program?

Siegfried Bernfeld, one of Freud's students, once observed that the trouble with self-analysis is the countertransference. The trouble with self-help therapies may be the client's own opposition or resistance to change. One might say that self-help programs succeed to the extent that they (1) help the client overcome his resistance to change, (2) augment his motivation for change, and (3) sustain change once it has been achieved.

An active ingredient in all forms of psychotherapy is the client's expectancy of help or of beneficial change. Promises or claims made by the author of a self-administered form of "treatment" may at times be as powerful as a budding relationship with a professional therapist whose reputation, credentials, interest, and encouragement are of course well known to give rise to placebo effects. Such effects may be very real and even long-lasting.

But what about the client's resistances? Researchers refer to frequent drop-outs in self-instructional programs, clients' failure to follow through on assigned procedures, poor compliance with therapeutic procedures, etc. Glasgow & Rosen (in press) identify these areas as most in need of attention in future research. I agree that, in general, the key to this problem is found in client characteristics. This appears to be true of psychotherapy, behavior therapy, as well as the self-administered programs under discussion here: Those who want to change, have the capacity to change, and receive a more or less powerful boost from an external source produce change whereas those who are deficient in motivation, personality resources, and/or receive inadequate help do not.*

*Hidden in these formulations is the problem of intentionality or will. As the recent upsurge of literature on self-regulation, self-control, and cognitive variables attests, the problem is always with us, whether we acknowledge it or not. How "id" becomes "ego," how one learns to achieve self-regulation or self-control when previously these have been deficient, how one can become assertive when previously one has been self-effacing--these are not primarily problems of technology. They bring us back to perennial philosophical problems of will and purpose which have never been squarely faced in contemporary psychology.

I, for one, fail to see how self-help programs, that are entirely self-administered, can deal effectively with the client's built-in reluctance. As clinicians are well aware, there are often intricate and complex reasons why people invest much effort in maintaining the status quo. By the same token, a therapist's attempts to dislodge or modify unrealistic beliefs and attitudes, maladaptive and self-defeating patterns of behavior that have become part of a person's life style, etc. often pose a challenge of major proportions. While people are understandably eager to embrace quick-and-simple solutions to their problems, and while Americans appear to be peculiarly vulnerable to salesmen and prophets, psychology as a profession has a clear responsibility to educate the public on the subject of realism and feasibility in the area of personality and behavior change. Dust jackets are often a poor guide to reality, and people will continue to look for utopias and panaceas. If as a profession we cater to these beliefs in magic or fail to dispel them, it is quite predictable who in the long run will be the loser.

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